General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Godalming Pharmacy, 34-36 High Street, GODALMING, Surrey, GU7 1DZ

Pharmacy reference: 1036588

Type of pharmacy: Community

Date of inspection: 17/09/2019

Pharmacy context

A community pharmacy set in a row of shops in the centre of Godalming. The pharmacy opens six days a week. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It supplies medicines to a few care homes and provides multi-compartment compliance packs to help people take their medicines. It delivers medicines to people who can't attend its premises in person. And it offers winter influenza (flu) vaccinations and a paid-for travel clinic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It generally keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They identify and manage risks appropriately. They understand their role in protecting vulnerable people. And they usually keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place for the services it provided. And they were in the process of being reviewed at the time of the inspection. The pharmacy's team members were required to read and sign the SOPs relevant to their roles.

The team members responsible for the dispensing process tried to keep the dispensing workstations tidy. They used plastic baskets to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who was also seen initialling the dispensing label.

Systems were in place to record and review dispensing errors and near misses. But near misses weren't always documented. The pharmacy's team members discussed their mistakes to share learning and help strengthen the pharmacy's dispensing process. They also tried to stop them happening again; for example, they've separated different pack sizes of the same medicines and some look-alike drugs to help reduce the risks of them picking the wrong product.

The pharmacy displayed a notice that identified the RP on duty. The roles and responsibilities of the pharmacy team were defined within the SOPs. And staff could explain what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist.

The pharmacy had a complaints process in place. Patient satisfaction surveys were undertaken annually. And the results of last year's survey were published online. Staff tried to keep people's preferred makes of medicines in stock when they were asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA).

The pharmacy's emergency supply records and its RP records were adequately maintained. The address from whom a controlled drug (CD) was received from wasn't always recorded in the pharmacy's CD register. But the CD register's running balance was checked every three months in line with the pharmacy's SOPs. The details of the prescriber were sometimes omitted or incorrectly recorded within the pharmacy's private prescription records. And the date an unlicensed medicinal product was obtained at the pharmacy wasn't routinely included in the pharmacy's specials records.

The pharmacy had an information governance policy. And its staff were required to read and sign a confidentiality and data protection declaration. Arrangements were in place for confidential waste to be destroyed securely. But sometimes people's details weren't removed or obliterated from patient-returned pharmaceutical waste before being disposed of. The pharmacy team removed confidential information stored in the consultation room. So, people using the GP video consultation service within it didn't have access to other people's personal details.

Safeguarding procedures and a list of key contacts for safeguarding concerns were available at the pharmacy. The superintendent pharmacist had completed level 2 safeguarding training. And some team members were trained dementia friends. Staff could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to deliver its services safely. And it encourages its team members to provide feedback and keep their knowledge up to date. But it doesn't always make sure its staff are put upon the right training course at the right time. The pharmacy team makes appropriate decisions about what is right for the people it cares for. Staff know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy opened for 49½ hours a week. It dispensed about 4,800 prescription items a month. The pharmacy team consisted of a full-time pharmacist (the superintendent pharmacist), a full-time medicines counter assistant (MCA), a full-time trainee MCA, a part-time counter assistant and a part-time delivery driver. The pharmacy has recently recruited a full-time dispensing assistant.

A locum pharmacist (the RP), the superintendent pharmacist, the MCA and the trainee MCA were working at the time of the inspection. A counter assistant was also present for some of the inspection. But it was her last shift working at the pharmacy. The pharmacy was reliant upon its team and locum staff to cover absences.

The pharmacy's team members were required to complete or undertake accredited training relevant to their roles. But the MCA and the trainee MCA hadn't completed nor were they undertaking accredited training for their dispensing roles in line with the GPhC's policy on minimum training requirements. But they were each enrolled upon an accredited training course for dispensing assistants following the inspection.

Staff supported each other so prescriptions were processed in a timely manner and people were served promptly. The pharmacists supervised and oversaw the supply of medicines and advice given by staff. A sales of medicines protocol was in place which the pharmacy team needed to follow. The trainee MCA described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for infants, people who were pregnant, elderly people or people with long-term health conditions.

The pharmacy's team members discussed their performance and development needs with the superintendent pharmacist informally throughout the year. They were encouraged to ask the superintendent pharmacist questions, familiarise themselves with new products and complete training provided by third-party companies to keep their knowledge up to date. Staff could train while they were at work when the pharmacy wasn't busy. Team meetings were held to update staff and share learning from mistakes or concerns. Staff unable to attend these meetings were updated during one-to-one discussions. Members of the pharmacy team felt comfortable in providing suggestions about the pharmacy during team meetings. And they knew how to raise a concern if they had one. Their feedback led to changes being made to the dispensary's layout.

The company didn't set targets nor incentives for its staff. And certain services, such as Medicines Use Reviews (MURs) and New Medicine Service (NMS) consultations, were only provided by suitably qualified pharmacists when it was clinically appropriate to do so and when the workload allowed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare. And its premises are clean and tidy.

Inspector's evidence

The pharmacy has been refurbished since its last inspection. And it had a suitably-sized consultation room if people needed to speak to a team member in private. Its dispensary had the storage and workspace it needed for its current workload. It was bright, clean, air-conditioned and professionally presented.

The pharmacy team was responsible for keeping the premises clean and tidy. The pharmacy's sinks were clean. And the pharmacy had a supply of hot and cold water. It also had appropriate handwashing facilities for its staff.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It provides services that people can access. It delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. And it gets its medicines from reputable sources and it usually stores them appropriately and securely. The pharmacy's team members check stocks of medicines to make sure they are fit for purpose. And they generally dispose of people's waste medicines safely too.

Inspector's evidence

There was no automated door into the pharmacy. But its entrance was level with the outside pavement and staff would open the door when necessary. So, people with mobility difficulties, such as wheelchair users, could access the premises. The pharmacy's services were advertised in-store. Staff were helpful and knew where to signpost people to if a service was not provided.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. An audit trail was maintained for each delivery and people were asked to sign a record to say they had received their medicines. The pharmacy provided over 20 MURS and about three NMS consultations a month. It also offered a needle exchange service. And needle exchange clients were asked to return spent sharps within the containers provided and deposit these into a designated receptacle. The pharmacy provided free emergency hormonal contraception to people through a locally commissioned patient group direction (PGD). It also provided a winter flu vaccination service. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. The pharmacy's travel clinic offered people travel vaccinations and malaria prevention medicines following a consultation with a suitably trained pharmacist. The pharmacy had valid and up-to-date PGDs in place for its travel clinic. People requiring travel vaccinations were asked to make appointments. So, the pharmacy's workload could be appropriately managed.

The pharmacy used a mixture of disposable and reusable systems for people who received their medicines in multi-compartment compliance packs. The pharmacy team needed to clean reusable compliance packs before filling them. An audit trail was maintained of the person who had assembled each compliance pack and who had checked it. A brief description of each medicine contained within the compliance packs was provided. But the date of dispensing wasn't always included on the compliance pack. And sometimes cautionary and advisory warnings about the medicines weren't printed on the backing sheets and patient information leaflets weren't always supplied. So, people didn't always have the information they needed to take their medicines safely.

Prescriptions were highlighted to alert staff when a pharmacist needed to counsel people and when CDs or refrigerated items needed to be added. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH, Alliance Healthcare, B&S, Sigma, Trident and Phoenix, to obtain its pharmaceutical stock. It kept its most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Its stock was subject to date checks,

which were documented, and products nearing their expiry dates were appropriately marked. It stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius.

The pharmacy team was required to store the pharmacy's CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. Staff were required to keep patient-returned and out-of-date CDs separate from in-date stock. But out-of-date CDs have been allowed to accumulate and needed to be destroyed in the presence of an authorised witness.

Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't verifying or decommissioning stock at the time of the inspection despite the pharmacy having the appropriate equipment and computer software to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. The pharmacy was scheduled to be FMD compliant by the end of the year.

Patient-returned waste was checked for CDs or prohibited items. People attempting to return prohibited items, such as household chemicals, were appropriately signposted. Pharmaceutical waste receptacles were available and in use. But the pharmacy didn't have a receptacle to dispose of people's hazardous waste, such as cytostatic and cytotoxic products.

A process was in place for dealing with recalls and concerns about medicines or medical devices. Drug and device alerts were received electronically and actioned by staff. And they sometimes annotated the alerts with the actions they took following their receipt.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely.

Inspector's evidence

The pharmacy had up-to-date reference sources available. And it had access to the NPA's information department. The pharmacy had a range of clean glass measures. And it had equipment for counting loose tablets and capsules too. The pharmacy had a medical refrigerator to store its pharmaceutical stock requiring refrigeration. The maximum and minimum temperatures of the refrigerator was monitored and recorded regularly. The pharmacy provided blood pressure checks on request. And its blood pressure monitor was replaced every two years.

Access to the pharmacy's computers and its patient medication record system was restricted to authorised personnel and password protected. The computer screens were out of view of the public. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.